Interim Report: Feedback Survey

The Sustainable Health Review Interim Report feedback survey consisted of 14 questions. The responses to the open feedback questions are detailed below. Responses to questions 9-12 have been published in a summarised report on the SHR website.

Your Personal Details	
1. **Title**	Mr ☐ Miss ☐ Mrs ☐ Ms ☐ Dr ☐ Other ☐
2. First Name(s)	
3. Surname	
4. Contact Details	
5. Organisation	Diabetes WA
6. Location	☒ Metropolitan ☐ Regional WA ☐ Outside WA
7. Are you providing a response on behalf of your group/organisation or as an individual? **(Required)**	☒ Group/organisation ☐ Individual ☐ Other, please specify: _____
Q8. Do you consent to your feedback being published, in summaries or in the Final Report? (Required)	
☒ I consent to my feedback being published ☐ I consent to my feedback being published anonymously ☐ I do not consent to my feedback being published	

The next two questions will allow you to provide more detailed feedback on how to maximise improvements in each of the Directions or suggest other areas or actions for the Sustainable Health Review Panel to consider to develop a more sustainable health system.

13. In regards to the 12 Directions, please provide detailed comments on how to maximise improvements in each of the Directions. Where possible, please indicate which Direction your comments relate to.

Direction 1 Keep people healthy and get serious about prevention and health promotion

Diabetes WA agrees that leadership is needed to develop whole of government targets for better health outcomes. Physical and social factors (such as income, education, housing, and access to nutritious food) do affect the incidence type 2 diabetes. Targets to effectively address these barriers will require whole of government coordination.

In relation to getting "serious about prevention and health promotion" it is important to highlight that prevention funding can be more effective when focused on initiatives which target high-risk individuals in addition to public health awareness campaigns. Type 2 diabetes can be prevented (or diagnosis delayed) in 60% of high risk individuals who receive an appropriate prevention intervention. Outcomes such as slowing the incidence of type 2 diabetes and its related complications have a flow on effect of savings for the health sector. The Let's Prevent pilot program currently funded in the Bunbury region partners with local government, health service stakeholders and community to recruit high risk individuals to participate in an evidence based intervention to reduce the incidence of chronic disease such as type 2 diabetes. The outcomes of this pilot should be closely watched as it will be assessing the feasibility of rolling out this type of proven prevention intervention in other WA regions. It will also evaluate the program using the Patient Activation Measure (PAM) which is capable of translation into savings to the health system. Diabetes WA would advocate for close monitoring/evaluation of any prevention initiative through measurement against objectives over short, medium and longer term time frames.

Women with Gestational Diabetes are at most risk of developing type 2 diabetes during their lifetime. Yet there are no structured initiatives in the system that address the longer term aspects for this group. In targeting women with GDM, the unborn child's health is also targeted making this an important group to focus on with prevention initiatives.

Direction 2 Focus on person-centred services

As identified in the Sustainable Health Review Interim Report a focus on person-centred services does require improved collaboration and systems integration within the health sector to aid patient navigation. However, a focus on person-centred services also requires the health sector to review the way we interact when providing health services. To provide health services in a person-centred way, the interaction must be undertaken by considering the person holistically including their social, mental and physical needs. This requires a cross government approach when planning health care services. It should not be assumed that health professionals routinely consider the person holistically when engaging on a specific aspect of a person's chronic condition. The mode of interaction should use techniques based in behavioural science and health professionals should be upskilled in these techniques (and quality assured) as this type of interaction has evidence of improved health outcomes in chronic disease.

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The service must be person centred in terms of care coordination and appropriate care pathways

Chronic conditions are complex and required a co-ordinated approach between the person's GP, health professionals in primary care, specialists and acute care. Better health outcomes could be achieved by devoting time and resources to linking existing systems and opening the dialogue between a person's multidisciplinary team. For example, Diabetes WA is working with Fiona Stanley Hospital to reduce outpatient waitlists by simply utilising the existing Central Referral Service (CRS) to refer "routine" (category 3) outpatient diabetes clinic referrals to existing self-management services which can be provided in primary care. The project builds on Fiona Stanley Hospital's success in developing and implementing changes to its outpatient Ear, Nose and Throat referrals by examining category 3 referrals. Work to examine existing services and how to streamline / link them should be prioritised.

Any proposed care pathway should be localised and based on the specific chronic disease. Diabetes WA has found that integrated pathways for diabetes self management simply don't exist in many areas and is currently working to develop a localised pathway for diabetes self-management in a major country region. Community consultation must be undertaken to understand existing local services and how to integrate them.

There are validated tools which can be used by the health system to measure whether a person centred approach is occurring, particularly in primary chronic condition care. For example, the PACIC tool can be used to measure patient experience in primary care services and benchmarks could be set around this along with quality improvement initiatives.

Direction 3: Better use of resources with more care in the community

As recognised in the Sustainable Health Review Interim Report technology such as telehealth can bring healthcare to a person cost effectively. However, the Sustainable Health Review should widen its consideration of this technology beyond the Emergency Telehealth Service Model and mental health. Diabetes Telehealth, a collaboration between Diabetes WA, WACHS and WAPHA, won the Director Generals Award at the 2017 WA Health Excellence Awards. In its first 2 years this service provided 1,400 occasions of service (diabetes self-management) saving significant kilometres of travel for consumers and is now being piloted to deliver endocrinology consultations. Diabetes WA and WACHS are also utilising the telehealth technology to upskill health professionals in the regions. The Department of Health should ensure its funding models encourage this type of collaboration (NGO's partnering together with State and Primary Care to deliver economical scaled up services instead of each NGO developing independent services, all with door opening costs). A coordinated and sustainable approach to funding telehealth should be undertaken to reduce duplication of infrastructure and the area of chronic conditions is ripe for this innovation.

The management of chronic conditions is mostly about self-management by the person living

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with the chronic condition. A person living with diabetes for example, will typically see their GP and other health providers for 8 hours in a year. This leaves around 8,750 hours a year where they are making decisions from day to day in order to best manage their condition. The WA Department of Health's Diabetes Service Standards 2014 state that on diagnosis, people should be offered structured diabetes self-management education. This should be done in a primary care setting. In the short term, structured diabetes self-management education aims to lower blood glucose levels. In the long-term, the skills developed during structured diabetes self-management education can mitigate further complications, morbidity, and premature mortality associated with the diabetes. GPs and specialists should have localised referral pathways to refer their patients into structured diabetes self management education as a matter of routine. Resources should be devoted to systems linking and the engagement of GPs to embed this but only supporting evidence based, effective programs using person centred approaches for best use of the health dollar.

Initiatives which train and upskill local health professionals to provide evidence-based health services in primary care such as the DESMOND (Diabetes Education and Self-Management for the Ongoing and Newly Diagnosed) program should be sustained. The training and quality management process required means that the DESMOND program can be delivered by a wide range of health professionals which significantly increases the capacity of the workforce to deliver in Country WA. In turn, this enables WA's limited number of Credentialed Diabetes Educators to focus on more specialised, high need areas such as diabetes in pregnancy and complex cases of diabetes.

Direction 5: New ways to support equity in country health

Improved patient transport strategies will support equity in country health in terms of tertiary/specialist care but we should also build on emerging work which enables better access to primary care in the community. For example, the Diabetes Telehealth services provided in partnership by Diabetes WA, WACHS and WAPHA has assisted many people in Country WA to access specialised diabetes self-management education to manage their chronic condition in community and potentially delay or reduce complications requiring specialist or tertiary care. The health sector should continue to support telehealth initiatives currently underway and encourage their integration to reduce duplication of effort.

Work has been made to achieve equity in Country Health through central coordination of the DESMOND program by Diabetes WA. Diabetes WA has trained several local health professionals in each region of country WA to deliver the diabetes self-management education programs but provides central coordination of bookings and administration from Perth. This reduces the administrative duplication at a local level and provides efficiencies. Further work could be done in this area to replicate the model in other chronic conditions.

Direction 6: Develop Partnerships for Aboriginal Health Outcomes

Models which build capacity in the Aboriginal health workforce to deliver quality self-

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management and other programs in a culturally appropriate manner should be considered. Capacity building can be achieved by devoting resource to training and accreditation (quality assessment) of a wide range of health professionals in the Aboriginal health workforce. Successful rolling out of health initiatives in Aboriginal communities can only be achieved by devoting resources to building relationships with local Aboriginal Medical Services and communities. The National Health and Medical Research Council (NH&MRC) has funded Diabetes WA in partnership with Charles Darwin University to determine the effectiveness of the only evidence-based, empirically tested and quality-assured diabetes self-management program which has been adapted for Aboriginal Communities. The research includes determining mechanisms for enabling long-term sustainability of the program in regional, rural and remote community contexts. It is envisaged that this will include the upskilling of community members in Aboriginal Communities.

Diabetes WA is piloting Video Call technology in 18/19 on behalf of WACHS to allow a flexible model for Aboriginal Communities. This is a result of engagement with rural and remote aboriginal health services who sought a flexible arrangement via 'virtual' waiting rooms and prompt access for opportunistic visits. These types of initiatives should be tried in the system and pursued if found to make a difference to service outcomes.

Direction 7: Create and support the right culture

This direction is closely aligned with Direction 2: Focus on Person Centred Services. The culture needs to move person centred care from a buzz term to reality, measure services delivered with the Health Care Climate Questionnaire, a validated tool which can be used to assess patients' perceptions of the degree to which their specific health professional is 'autonomy supportive' and is currently used in all programs across the country via the NDSS and Diabetes Telehealth Service. As discussed above, a culture of person centred care requires upskilling health professionals in behavioural sciences and listening techniques. Part of instilling a culture which focuses on the person requires a focus on consumer (aka customer) satisfaction. The Net Promotor score is a widely used objective and validated tool to achieve this which can be applied to health services but allows benchmarking against many other industries. As per Direction number 2, the PACIC tool could also be a measure of cultural change in HP staff.

Direction 8: Greater use of technology, data and innovation to support consumers and clinicians and drive change

In addition to linking WA Health data, we need to encourage State and Commonwealth linkages of data and technology immediately. There are many current IT projects being developed in parallel at the State and Commonwealth levels without being linked.
As an example, Diabetes WA has advocated for the NDSS registration (currently a stand along system) to be linked with a person's Medicare card.

To encourage innovation, use a system such as that in the NHS called 'test bed' where industry innovation can be tested in the real world and organisations can apply for funding to explore

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whether various approaches are right for the system (or not).

Direction 9: Harness and Support health and medical research collaboration and innovation

The 4 main categories of research listed in the Sustainable Health Review Interim Report: public health research; basic research; clinical research; and health services (systems) research, need to
broaden or encompass research into secondary prevention. By this we mean translational research into behaviour change which will lead to improve health outcomes for people with chronic conditions. In July 2016, in partnership with Charles Darwin University, Diabetes WA has successfully applied for funding through the National Health and Medical Research Council which is currently determining:
- Whether the DESMOND (Diabetes Education and Self-Management for the Ongoing and Newly Diagnosed) program which has been adapted for Aboriginal communities is experienced as culturally appropriate safe and secure;
- The effectiveness of the program to enhance an individual's self-management capability, improve their social emotional wellbeing, reduce smoking rates and improve metabolic markers of diabetes control; and
- How to enable long term sustainability and fidelity of DESMOND in regional rural remote and Aboriginal community contexts.
Diabetes WA welcome further NH&MRC research grants to explore effective chronic condition management technologies in order to reduce the long term health complications for consumers and the associated costs to the health system.

Direction 10: Develop a supported and flexible workforce

The Sustainable Health Review Interim Report observes a need to prepare for a more diverse, agile and fit-for purpose workforce. In order to do this, resource must be devoted to training and accreditation (including quality assessment) of a wide range of health professionals. For example, DESMOND allows the health sector to tap into a wider range of health professionals (for example pharmacists, dietitians, exercise physiologists, nurses, podiatrists) to boost capacity beyond credentialed diabetes educators to deliver basic diabetes self-management education. In this way Health Professionals can be used to their full capacity in the area of chronic conditions.

Direction 11: Plan and invest more wisely

Diabetes WA support's the Sustainable Health Review Interim Report observation that funding should be directed to services that are backed by evidence that they are effective. This means only funding health programs/initiatives with a strong or emerging outcome evidence base. Robust evaluation must be built into any activity undertaken to measure whether the activity led to improved health outcomes. In providing more care in the community, the health sector should fund genuine health outcomes, rather than outputs. Funding models be flexible/agile to allow

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services to change if they are not providing appropriate health outcomes.

Review and alignment of services would also lead to wiser planning - it would be ideal to see the programs and services available under the NDSS better integrated into WA's health sector. Currently, Diabetes WA are actively advocating for this to occur.

Direction 12: Building financial sustainability, strong governance, systems and statewide support services

In its role as a Systems Manager, the Department of Health must have multiple levels of consultation about how the system is operating on the ground and how it has organically developed. Diabetes WA supports approaches to funding which will provide sustainability including those which include collaboration to avoid the duplication which currently exists in the health sector. It is time to pull resources together and fund for quality, positive impact consumers and simplified navigation of the health system. Change management will be key here.
Planning of services requires consideration of all stakeholders with evaluation built in from the beginning of a service so that accountability can be measured. Results from evaluation need to be reflected and the system constantly looking to improve. Sustainability means being effective against defined objectives and asking if we can do things better next time.

14. Is there anything else that the Panel has missed so far that is important in developing a more sustainable health system for Western Australia?